STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN TREE AT POST ROAD	8800 SPOON DR INDIANAPOLIS, IN 46219

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R0000	This visit was for the Investigation of Complaint IN00108852. Complaint IN00108852 - Substantiated. No deficiencies related to the allegation are cited. Unrelated deficiencies are cited. Survey date: May 31, 2012 Facility number: 011799 Provider number: 011799 AIM number: N/A Survey team: Diana Zgonc RN, TC Connie Landman RN Christi Davidson RN Lori Brettnacher RN Census bed type: Residential: 31 Total: 31 Census payor type: Other: 31 Total: 31 Sample: 3 These state findings are cited in	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	accordance with 410 IAC 16.2. Quality review 6/06/12 by Suzanne Williams, RN			

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R0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure all residents were free of neglect and kept from elopement for 1 of 3 residents reviewed for abuse and neglect in a total sample of 3 residents (Resident C). Findings include: Resident C's record was reviewed on 5/31/2012 at 9:30 A.M.. Resident C was admitted to the facility on 4/14/2012 and had current diagnoses, which included dementia, Parkinson's disease, and depression. A document titled "Cognitive Assessment Tool Guide" dated 4/14/2012, indicated Resident C was in the early stages of dementia, was ambulatory with a history of falls, had delusions, hallucinations/paranoia and exhibited exit seeking behaviors frequently, making her an elopement risk. Resident was admitted to this facility due to being an elopement risk. During an interview on 5/31/2012 at 9:10	R0052	The resident did pull the fire alarm. The staff did take the resident to her apartment and continued to take other residents to their apartments; following proper procedures. Immediately following asisting all residents to their apartments the staff did a count of all in-house residents and discovered the one resident missing. The licensed nurse called the police, the nursing director, and the family. A search of the facility and grounds was simultaneously in process. The nursing director called the executive director and the emergency phone list was being called.The total time from the resident being assisted to her apartment and the resident's return to the facility was approximately 40 minutes.What corrective action will be accomplished for those residents found to have been affected by the deficient practice:The Resident was placed with a 24 hour care giver immedately.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective	07/17/2012

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	A.M., the Executive Director (ED) indicated Resident C eloped last night (5/30/12) around 8:00 P.M. The resident has been on 15 minute checks since she had been at this facility because she was an elopement risk. She pulled the fire alarm which unlocked the doors and escaped. The ED indicated her staff reported that when the alarms went off, they put Resident C in her room and continued with fire emergency procedures. They were not aware Resident C had left her room and escaped from the building. She walked to 15th Street (approximately four blocks away) into someone's garage and refused to leave. Someone at that house called the police, and the police brought Resident C back to the facility. As far a she knew, Resident C was out of the building not more than 40 minutes. Observation of this facility on 5/31/2012 revealed a retention pond on the property located in the direction the resident had walked. The facility was located on a busy main thoroughfare. During an interview on 5/31/2012 at 10:50 A.M., Licensed Practical Nurse (LPN) #1 stated, "DON (Director of Nursing) named) makes the decisions on when to take them off of 15 minute checks." LPN		action will be taken:All residents residing in the Samara memory care unit have the potential to be affected by the same practice.Fire Drills will occur monthly rotating between shifts. A resident count will occur as part of the fire drill procedure; the count will be kept with the fire drill documentation. One staff member will be stationed in the front hallway on each floor in order to be able to observe the doors. The licensed nurse will silence the alarm, to lessen the anxiety of the memory care residents, and one staff member will be stationed outside the locked doors by the stairwell and the elevator in order to be able to observe the doors.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The staff was in-serviced on May 31, 2012 in the All Staff Meeting with the following agenda: Fire Drills, Safe Heavens and Safety. The above stated procedure will be practiced during fire drills monthly.How the corrective action will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place and ;The Nursing Director and / or Designee, the Facility Safety Officer (Maintenance Director) and / or Designee will monitor the fire drills and report monthly the	

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	#1 indicated at this time if it were the weekend and the DON was not here, they would contact her if Resident C was exhibiting exiting behaviors and as a nursing measure, would put her on 15 minute checks. During an interview on 5/31/2012 at 10:55 A.M., RCA #2 (Resident Care Assistant) indicated Resident C was on and off of 15 minute checks, and she was not sure what warranted putting her on or off of 15 minute checks. During an interview on 5/31/2012 at 11:09, LPN #3 indicated he was new and did not know what the procedure was for implementing 15 minute checks. He stated, "It is given to me in report if she is on 15 minute checks and I would put her on 15 minute checks if she was exit seeking or fell." Resident C's current May 2012 service plan indicated she was an elopement risk and staff would observe her closely. The service plan lacked documentation of the need for 15 minute checks or any other specific interventions to inform the staff of how and when to implement 15 minute checks. A document provided by the ED (Executive Director) on 5/31/2012 at 1:20		results and training exercise in the safety meeting.By what date the systemic changes will be completed:July 17, 2012	

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	P.M. titled "Content of All Staff Inservice 1/18/2012" indicated the security doors de-activated when the fire alarms went off or during a power outage so the doors must be monitored and the residents observed closely. Nurses' notes from 4/15/2012 to 5/31/2012 were reviewed. A nurse's note dated 4/15/2012-2 P.M. indicated, "Resident was very confused, attempted to leave thru-out the day and became angry when she couldn't leave. Resident was up and active until after lunch and then had visitors and then napped. Will continue to monitor and keep active." The clinical record lacked documentation of 15 minute checks being implemented or further monitoring of the resident on this day. A nurse's note dated 4/16/2012 at 12:30 P.M. indicated, ". . .She was still confused and wanting to leave. Continued to redirect and keep busy with activities. Will continue to monitor." Documentation of further monitoring or 15 minutes checks were not documented on this day. A nurse's note dated 4/18/2012 at 2:20 P.M. indicated, "Resident doing well, still confused and seeking exit. . ." Further documentation of monitoring or 15 minute checks were not documented on this day.			

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	A nurse's note dated 5/18/2012 (not timed), indicated, "Informed by staff that resident was exit seeking earlier in the week and took the fire extinguisher hoping it would help them (another res was with her) get out. Also today resident was again exit seeking and had to be redirected several times by staff." Documentation of when "earlier this week" was unavailable. The next nurse's note dated 5/21/2012 (not timed), indicated, "Resident was exit seeking all afternoon and had to be redirected several times by staff. Will continue to monitor." Documentation was not available of monitoring or 15 minute checks that day. A nurse's note dated 5/22/2012 at 3:30 P.M. indicated, "Resident exit seeking all day and confused another resident as being her husband. Redirected several times and will continue." Documentation of monitoring or 15 minute checks were not available for this date. A nurse's note dated 5/23/2012, timed 2200 (10:00 p.m.), indicated, "Res. has been exit seeking this shift (3-11). Wanting to know who has the keys to the doors so she can leave. Continue to redirect res." Documentation of monitoring or 15 minute checks were not available. During an interview on 5/31/2012 at			

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	11:00 A.M. the DON indicated orders were not needed to implement 15 minute resident checks. If a resident was an elopement risk or had frequent falls they would be on 15 minute checks. She indicated staff might call her to talk about behaviors then implement the 15 minute checks for however long they needed to be implemented. There wasn't a specific policy, procedure, or training on when to know how to implement the checks, just generalized training on dementia that all staff received. At this time the ED who was present for this interview indicated the facility was locked and everyone in the facility was an elopement risk so 15 minute checks aren't always immediately implemented only if a resident is acting unusual. She stated, "With Memory Care residents-moment to moment thing. Anything unusual, not normal for that resident-would do 15 minute checks. Knowing our residents' behaviors can change. Does that person need extra watching for an hour, a day, whatever they do, we react." The ED further indicated the facility provided the staff with Memory Care Training before they started working, but she was unable to provide documentation it was done.			